

deviated towards the ulnar side. The left middle finger was shorter than the one on the right side. No movements were possible at the inter-phalangeal joint and the finger was fixed in extension. X-ray showed a stave fracture of the head of the proximal phalanx which had united in a bad position.

Treatment.—Under ethyl-chloride-ether anaesthesia, the ends of the bones were exposed by a dorso-lateral incision and excised subperiosteally after lifting the attachment of the flexor sublimis digitorum and interossei from the second phalanx. The head of the



Fig. 1.

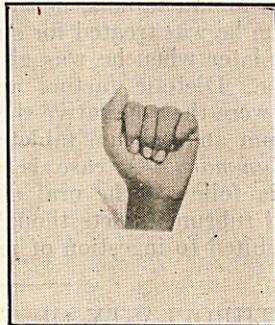


Fig. 2.

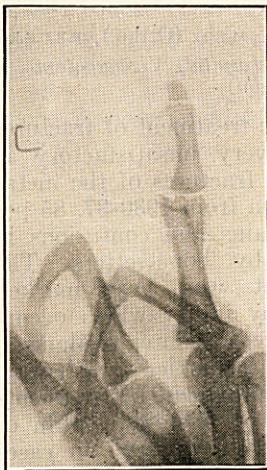


Fig. 3.

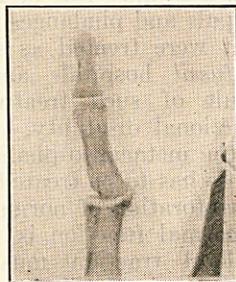


Fig. 4.

Fig. 1.—The clinical result after arthroplasty of the first inter-phalangeal joint of the left middle finger. Note the extension of the finger.

Fig. 2 illustrates the flexion after arthroplasty.

Fig. 3.—Lateral view of the first inter-phalangeal joint showing a stave fracture of the head of the first phalanx with mal-union.

Fig. 4.—The condition after arthroplasty two years after operation. Note the concave upper end of the first phalanx and convex surface of the second phalanx at its base.

proximal phalanx was made concave and the base of the distal phalanx was made convex and the two ends were covered by fascia lata from the thigh. The wound was sutured in layers. Skeletal traction was obtained by a Kirschner's wire inserted through the distal phalanx with a special clamp made for the finger extension. A special extension splint was made by incorporating a loop of stout wire in plaster of Paris applied to the forearm.

The sutures were removed on the 10th day. On the 14th day the extension was removed and the finger was gradually flexed actively and maintained in that position until complete flexion was obtained, which

took five days. Afterwards active flexion and extension was encouraged with massage for a fortnight, at the end of which period the man went home with advice to carry on the treatment.

He reported in 1938 with the functional result shown by the pictures and the x-rays. Though the finger is definitely shorter and ugly to look at, the student has a very firm and good grip and active flexion and extension are very satisfactory.

Points of interest

Arthroplasty of the first inter-phalangeal joint is a difficult problem, because of the fact that active flexion and extension at this joint are entirely done by the flexor sublimis digitorum and the interossei, respectively. While doing arthroplasty this attachment should be carefully preserved and if it has to be detached it must be reinserted at a distal level by transplantation technique. In this case it was not necessary to do so. The insertions of the flexor sublimis and interossei were easily lifted off the bone along with the periosteum and enough bone was removed to get a gap of half an inch after excision.

AN UNUSUAL CASE OF CUT THROAT

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A Hindu male, aged 30 years, was dismissed from his appointment as a police clerk in Jaipur police station in May 1935. He came to Burma and worked as petition writer in Pyuntaza post office from where he was also dismissed. He became a *Sadhu* in December 1935 and roamed about the country. On the 8th January, 1936, some unknown men were said to have attacked him with *dahs* and inflicted a severe cut-throat wound and a large incised wound on the penis. He was said to have struggled along for three days with these injuries and reached a hut and from there he was brought by the police to Shwegyin civil hospital. The wounds were described on his history ticket as follows:—

1. A long incised wound on front of penis, muscle deep; wound is full of maggots.
2. Incised wound $6 \times 1\frac{1}{2}$ inches and cutting the larynx and pharynx through above the thyroid cartilage.

The wound in the throat stitched up and a laryngotomy tube inserted. The patient was very emaciated. His eyes were sunken and with the gaping throat the wound presented a horrible sight. He could not make himself understood because he had lost his voice. Only after the wound was stitched up and bandaged and the patient kept a hand on it, could he produce a feeble whisper. He was given rectal feeds. Three days later the wound in the neck became septic, discharging pus freely and the stitches gave way and had to be removed. The patient was then fed through the neck wound. On the 19th January, 1936, nasal feeding was tried and proved to be satisfactory. The patient gave trouble, refused to accept food and tried to run away.

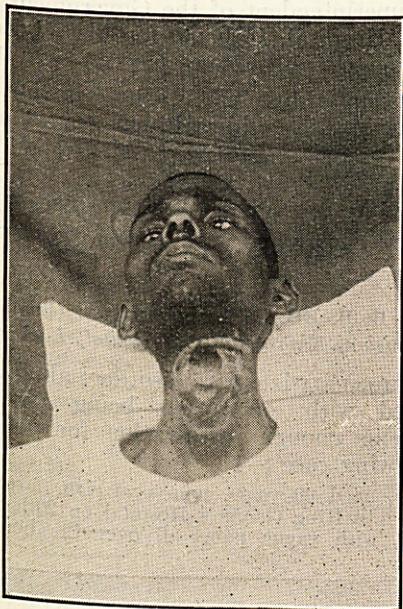
(For the above notes I am grateful to my assistant at Shwegyin, Dr. Hans Raj.)

The patient was transferred to the Headquarters civil hospital, Toungoo, on the 22nd January. The journey took about 10 hours.

On admission the wounds were described as follows:—

1. One septic incised wound on the upper part of the neck extending from one angle of the jaw to the other cutting through the throat above larynx and cesophagus partially.

2. Incised wound at root of penis, one inch broad'. The patient was in an extreme state of emaciation due to starvation. The first photograph was taken after the patient had been in hospital for about ten days. He was too weak to sit up and could not even hold his head up. Physical examination was otherwise



negative. The following structures could be identified as having been cut—skin, platysma, suprathyroid muscles, thyro-hyoid membrane, part of sterno-mastoids and epiglottis. The posterior wall of the pharynx was exposed and the retraction of the skin had exposed the upper part of the thyroid cartilage.

The patient was fed through the wound with a tube and funnel and seemed to be perpetually hungry. Four pints of milk with eggs, sugar and glucose were given



each day. The wound became quite clean and the patient's general condition improved day by day. On 20th February the wound was stitched up under local anaesthesia; the base of the epiglottis was also pulled down and stitched into place as I imagined that this

procedure would be necessary for the proper performance of swallowing. The head was kept hyperflexed. The patient received food surreptitiously from neighbours and developed a cough which burst several of the sutures. As bleeding occurred from the raw areas, the other stitches had to be removed to facilitate pressure on bleeding points by the dressing. Having read in the *Medical Annual* of 1928 and of 1929 notes on treatment of gaping wounds by skin traction and adhesive strapping, I decided to try the method in this case. The edges of the wound were kept approximated by sticking plaster and bandage and the patient was enjoined to keep the head flexed and placed in the propped-up position. He was fed through the nose quite easily. His weight and general condition improved steadily and the wound also became smaller and smaller. By 2nd April, only a small hole was left in place of the previous gaping wound. This is shown quite clearly in the second photograph which was taken about this time. He was discharged from the hospital on the 14th May with only a small scar left to indicate the wound.

Commentary

More on account of worry due to precarious livelihood than to any other cause, the patient must have developed suicidal mania, and mutilated himself and attempted to commit suicide by cutting his own throat. It was sheer good luck that the big vessels in the neck escaped division. This might be explained by the fact that in his frenzy in attempting to make a good job of it, he hyperextended his neck, thereby pushing the big vessels posteriorly in the level of the wound. My idea that anatomical result should be perfect to enable the swallowing act to be normal was proved to be wrong because in spite of the fact that the cut ends of the epiglottis were not united swallowing was normal and no solid or liquid food entered the trachea.

The case illustrates the utility of approximating the edges of a wide wound by means of plaster or other means to promote healing.

SPONTANEOUS SUBARACHNOID HÆMORRHAGE

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PATIENT, male, aged 22 years, was admitted into the Government Headquarters Hospital, Calicut, on 20th September, 1938, at 10-30 a.m. with severe headache and restlessness.

The history was that on 17th September at about 8-30 p.m. the headache started suddenly and became intense in a few minutes. He vomited the food he had taken a few minutes previously. A doctor was sent for who gave an injection. The patient's condition was so upsetting that within a few minutes another doctor was called in and gave another injection without any benefit. What was injected is not known. The patient continued in this state of agonizing headache till next morning, when yet another doctor was called in under whose care he remained for two days with no improvement. On the 20th morning he was admitted into the hospital.

Previous history.—Four months ago he had a fall from a height of about 20 feet hitting the left side of his head on the ground. He was unconscious for ten days and when he recovered he had lost the vision of his left eye with no other sequelæ.

On admission, temperature 97.4°F., pulse 54, blood pressure 110/84. Patient was confused, pupils dilated.